DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Ambulatory Surgery Centers
Managed Care Plans

Memorandum No: 05-36 MAA
Issued: July 1, 2005

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Ambulatory Surgery Centers (ASC): Additions and Deletions to CPT and HCPCS* Codes Allowed in the ASC Fee Schedule

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will adopt the 2005 Medicare Fee Schedule Database (MFSDB) Ambulatory Surgery Centers groupers for the new July 1, 2005, CPT™ procedures. MAA has adopted the CMS July 2005 additions and deletions.

Maximum Allowable Fees

The 2005 Washington State Legislature **has appropriated a one (1.0) percent vendor rate increase** for the 2006 state fiscal year. The new maximum allowable amounts are shown below:

Group	July 1, 2005 Maximum Allowable
1	$305.23
2	$336.04
3	$362.97
4	$411.24
5	$442.31
6	$495.41
7	$558.32
8	$640.87
9	$915.71

All procedures performed in an ASC are subject to the parent program guidelines. **For example:** Surgeries are subject to the Physician-Related Services Washington Administrative Code (WAC) and *Physician-Related Services Billing Instructions;* dental procedures are subject to the Dental-Related Services WAC and *Dental Program Billing Instructions*.

* CPT stands for Current Procedural Terminology
HCPCS stands for Healthcare Common Procedure Coding System

Procedure Code Changes

Effective for dates of service on and after July 1, 2005, MAA will add the following procedure codes to those procedures that are payable when performed or provided in an ASC:

Added Procedure Code	Brief Description	Group	Type of Prior Authorization Required
15001	Skin graft add-on	1	-
19296	Place PO breat cath for rad	9	PA
19298	Place breast rad tube/caths	1	PA
21120	Reconstruction of chin	7	PA
21125	Augmentation, lower jaw bone	7	-
28108	Removal of toe lesions	2	-
29873	Knee arthroscopy/surgery	3	-
30220	Insert nasal septal button	3	-
31545	Remove VC lesion w/scope	4	-
31546	Remove VC lesion scope/graft	4	-
31603	Incision of windpipe	1	-
31636	Bronchoscopy, bronch stents	2	-
31637	Bronchoscopy, stent add-on	1	-
31638	Bronchoscopy, revise stent	2	-
33212	Insertion of pulse generator	3	-
33213	Insertion of pulse generator	3	-
33233	Removal of pacemaker system	2	-
36834	Repair A-V aneurysm	3	-
37500	Endoscopy ligate perf veins	3	-
42665	Ligation of salivary duct	7	-
43237	Endoscopic Us exam esoph	2	-
43238	Upper GI endoscopy w/us fm bx	2	-
44397	Colonscopy w/stent	1	-
45327	Proctosigmoidoscopy w/stent	1	-
45341	Sigmoidoscopy w/ultrasound	1	-
45342	Sigmoidoscopy w/us guide bx	1	-
45345	Signoidoscopy w/stent	1	-
45387	Colonoscopy w/stent	1	-
45391	Colonscopy w/endoscope	2	-
45392	Colonscopy w/endoscoic frib	2	-
46230	Removal of anal tags	1	-
46706	Repr of anal fistula w/glue	1	-
46947	Hemorrhoidopexy by stapling	3	-
49419	Insrt abdom cath for chemotx	1	-
51992	Laparo sling operation	5	-

Added Procedure Code	Brief Description	Group	Type of Prior Authorization Required
52301	Cystoscopy and treatment	3	-
52402	Cystourethro cut ejacul duct	3	-
55873	Cryoablate prostate	9	PA
57155	Insert uteri tandems/ovoids	2	-
57288	Repair bladder defect	5	EPA
58346	Insert heyman uteri capsule	2	-
58565	Hysteroscopy sterilization	4	-
62264	Epidural lysis on single day	1	-
64517	N block inj hypogastric plexus	2	-
64561	Implant neuroelectrodes	3	-
64681	Injection treatment of nerve	2	-
65780	Ocular reconst transplant	5	PA
65781	Ocular reconst transplant	5	PA
65782	Ocular reconst transplant	5	PA
65820	Relieve inner eye pressure	1	-
66711	Ciliary endoscopic ablation	2	-
67343	Release eye tissue	7	-
67445	Expir/decompress eye socket	5	-
67570	Decompress Optic Nerve	4	-
67912	Correction eyelid w/implant	3	PA
68371	Harvest eye tissue, allograft	2	PA
D0140	Limit oral eval problem focus	2	-
D0150	Comprehensve oral evaluation	2	-
D1120	Dental prophylaxis child	2	-
D1351	Dental sealant per tooth	2	-
D1510	Space maintainer fxd unilat	2	-
D1515	Fixed bilat space maintainer	2	-
D1550	Recement space maintainer	2	-
D2140	Amalgam one surface, permanent	2	-
D2150	Amalgam two surfaces, permanent	2	-
D2160	Amalgam three surfaces, permanent	2	-
D2161	Amalgam 4 or > surfaces, permanent	2	-
D2330	Resin one surface-anterior	2	-
D2331	Resin two surfaces- anterior	2	-
D2332	Resin three surfaces- anterior	2	-
D2335	Resin 4/> surf or w incis an	2	-
D2390	Ant resin-based cmpst crown	2	-
D2391	Post 1 srfc resin based cmpst	2	-
D2392	Post 2 srfc resin based cmpst	2	-
D2393	Post 3 srfc resin bsed cmpst	2	-

Added Procedure Code	Brief Description	Group	Type of Prior Authorization Required
D2394	Post >=4 srfc resin based cmpst	2	-
D2910	Recement inlay onlay or part	2	-
D2920	Dental recement crown	2	-
D2930	Prefab stnlss steel crwn primary	2	-
D2931	Prefab stnlss steel crown permanent	2	-
D2933	Prefab stainless steel crown	2	-
D2950	Core build-up incl any pins	2	-
D3220	Therapeutic pulpotomy	2	-
D3310	Root canal therapy - Anterior	2	-
D3320	Root canal therapy 2 canals	2	-
D3330	Root canal therapy 3 canals	2	-
D3346	Retreat root canal anterior	2	PA
D3347	Retreat root canal bicuspid	2	PA
D3348	Retreat root canal molar	2	PA
D3351	Apexification/recalc, initial	2	-
D3352	Apexification/recalc, interim	2	-
D3410	Apicoect/perirad surg anterior	2	-
D3421	Root surgery bicuspid	2	-
D3425	Root surgery molar	2	-
D3426	Root surgery ea add root	2	-
D3430	Retrograde filling	2	-
D3950	Canal prep/fitting of dowel	2	-
D4210	Gingivectomy/platy per quad	2	-
D4341	Periodontal scaling & root	2	-
D4342	Periodontal scaling 1-3 teeth	2	-
D4910	Periodontal maint procedures	2	-
D7111	Extraction coronal remnants	2	-
D7140	Extraction erupted tooth/exr	2	-
D7210	Rem imp tooth w/mucoper flp	2	-
D7220	Impact tooth remove soft tissue	2	-
D7230	Impact tooth remove part bony	2	-
D7240	Impact tooth remove comp bony	2	-
D7241	Impact tooth rem bony w/comp	2	-
D7250	Tooth root removal	2	-
D7270	Tooth implantation	2	-
D7280	Exposure impact tooth orthod	2	-
D7283	Place device impacted tooth	2	PA
D7285	Biopsy of oral tissue hard	2	PA
D7286	Biopsy of oral tissue soft	2	PA
D9220	General Anesthesia	2	-

Added Procedure Code	Brief Description	Group	Type of Prior Authorization Required
D9241	Intravenous sedation	2	-
D9610	Dent therapeutic drug inject	2	-

Effective for dates of service on and after July l, **2005,** MAA will delete the following procedure codes from the list of procedures that are payable when performed or provided in an ASC:

21440	23600	23620	53850	69725

Place of Service Code Required for Ambulatory Surgery Centers

Effective for dates of service on and after August 1, 2005, when billing MAA for ASC services, you must put place of service code 24 in box 24B of the HCFA-1500 claim form.

Ambulatory Surgery Centers Fee Schedule

To obtain the new ASC fee schedule, visit MAA's website at http://maa.dshs.wa.gov. Click on the Billing Instructions/Numbered Memoranda link and then on the Fee Schedules link.

Bill MAA your usual and customary charge.

Billing Instructions Replacement Pages

Attached are replacement pages 11-12, 31-34, 37-40, and A.1-A.56 for MAA's current *Ambulatory Surgery Centers Billing Instructions*.

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4^{th} or 5^{th} digits when applicable) or the entire claim will be denied.

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria

BLADDER NECK SUSPENSION

CPT Codes: 57288 and 57289

201 Diagnosis of ***stress urinary incontinence*** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; *and*
2) Surgically sterile or past child bearing years; *and*
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; *and*
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck; *and*
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

BLEPHAROPLASTIES

CPT Codes: 15822, 15823, and 67901 – 67908

630 Blepharoplasty for noncosmetic reasons when **both** of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; **and**
2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

OTHER REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA

250 Reduction mammoplasty or mastectomy, not meeting expedited prior authorization criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA

CPT Codes: 19318 and 19140

Associated ICD-9-CM Diagnosis codes: 611.1 (Hypertrophy of Breast) or 611.9 (Gynecomastia)

241 Diagnosis for ***hypertrophy of the breast*** with:

1) Photographs and client's chart; **and**
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia; **and**
   b) Conservative treatment not effective; **and**
3) Abnormally large breasts in relation to body size with shoulder grooves; **and**
4) Within 20% of ideal body weight; **and**
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for ***gynecomastia***:

1) Pictures in client's chart; **and**
2) Persistent tenderness and pain; **and**
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Code	Criteria

STRABISMUS SURGERY
CPT Codes: 67311 – 67340

631 Strabismus surgery for clients 18 years of age and older when **both** of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

VAGINAL HYSTERECTOMY
CPT Code: 58550

111 Diagnosis of **abnormal uterine bleeding** in a client 30 years of age or older with *two or more* of the following conditions:

1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months.
2) Documented hct of less than 30 or hgb less than 10.
3) Documentation of failure of conservative care i.e.: d&c, laparoscopy, or hormone therapy for at least three months.

112 Diagnosis of **fibroids** for any *one* of the following indications in a client 30 years of age or older:

1) Myomata associated with uterus greater than 12 weeks or 10cm in size
2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct less than 30 or hgb less than 10
3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.

113 Diagnosis of **symptomatic endometriosis** in a client 30 years of age or older with the following:

1) Significant findings per laproscope; *and*
2) Unresponsiveness to 3 months of hormone therapy or cauterization.

114 Diagnosis of **chronic advanced pelvic inflammatory disease** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: When applicable, enter additional information such as indicator "B" to indicate baby on parent's PIC.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 2000 = 040400). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter 24 (ambulatory surgery center).

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCS) or state unique procedure code from the fee schedule in these billing instructions for the services being billed. **MODIFIER** – When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address*, and *Telephone Number* on all claim forms.

PIN: Enter the seven-digit number assigned to you by MAA here.

Sample HCFA-1500 Form

(To be included prior to publication)

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2000 = 040400). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **24** (ambulatory surgery center).

24C. **Type of Service**: Required. Enter **Z** (ambulatory surgery center).

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed. **Coinsurance and Deductible**: Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the appropriate number of units.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the occupational therapy clinic or individual number assigned to you by MAA.

Sample Medicare Part B/Medicaid Crossover Form

(To be included prior to publication)

Fee Schedule

The Medical Assistance Administration (MAA) uses Medicare's guidelines to identify and group surgery procedures that are appropriate in a freestanding ambulatory surgery center setting. In addition, MAA uses procedure codes not covered by Medicare but grouped using Medicare's guidelines. These procedures have been classified into eight groups. A single maximum allowable for the facility fee has been established for each group as follows. Providers must bill professional fees separately.

Group	July 1, 2005 Maximum Allowable
1	$305.23
2	$336.04
3	$362.97
4	$411.24
5	$442.31
6	$495.41
7	$558.32
8	$640.87
9	$915.71

MAA covers only the procedure codes listed on the attached fee schedule in ambulatory surgery centers.

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